DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345403	B. WING	B. WING			C 02/27/2014	
NAME OF P	NAME OF PROVIDER OR SUPPLIER		•	s	TREET	ADDRESS, CITY, STATE, ZIP CODE	J	
CARY HE	ALTH AND REHABILITAT	TON		6	590 TR	YON ROAD		
OAK! EL	ALITI ARD REIMOLITAT			0	ARY,	NC 27518		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE
	Based on the resident assessment, the facilities resident who enters the indwelling catheter is resident's clinical concatheterization was now ho is incontinent of treatment and service infections and to restefunction as possible. This REQUIREMENT by: Based on observation record reviews, the faindwelling catheter for with an indwelling catheter fo	t's comprehensive ity must ensure that a he facility without an not catheterized unless the dition demonstrates that ecessary; and a resident bladder receives appropriate as to prevent urinary tract ore as much normal bladder. It is not met as evidenced and staff interviews and acility failed to secure the r 1 of 3 sampled residents heter (Resident #6). The shitted to the facility on diagnoses including oper/lower and right upper oure ulcers. The admission Set) assessment dated to Resident #6 was non agnitive impairment and sistance with all activities of #6 was had a stage IV in indwelling catheter. an 's order dated 9/12/13, is for the catheter was due he catheter should be	F	315	3.	The corrective action taken for the alleged deficient practice we to attach the leg strap to the catheter tubing and apply it to Resident #6's leg. Current residents with indwellicatheters were audited for presence of leg straps with any adjustments or additions made immediately. Future admission or readmissions will be evaluated upon admission for an indwellicatheter to ensure the catheter's tubing is strapped appropriated. The Nursing staff was educated by the Director of Clinical Services (DCS) or the Assistant Director of Clinical Services (ADCS) on the proper use of Foley Catheter leg straps and placement of the drainage bag. Any new hires in the future with be given the same education during their orientation proces. The DCS or her designee will audit residents with catheters of the presence of leg straps daily for 1 month, then once per weef for 1 month, then once a month for 3 months. Any issues identified will be addressed an corrected as needed.	ing ins ted ing s y d tt	
LABORATORY	1	n on 2/26/14 at 9:40AM, SUPPLIER REPRESENJATIVES SIGNATURE	=		<u></u>	N TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF B	BOADES OF SHIPPITED	345403	1	OTOTET ADDDESS OFTW OTATE AND CODE	02/27/2014	
NAME OF PROVIDER OR SUPPLIER CARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY, NG 27518			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 315	Resident #6 was lying covering body in a ful with both arms and le chest. There was no I the catheter bag was waist level of the resident was responded and increase of the catheter bag has been placed on the occasions. During an observation Resident #6 remained catheter bag remained There was no leg strated the bed frame and the continued to thicken, the resident. During an interview and Nurse#1 stated that the catheters should have catheter tubing. She I #6 did not want the state or understand the Nurse#1 also indicate should be followed on checking the catheter secured; Nurse #1 conot secured.	g in bed with sheets half way ly contracted fetal position fit leg contracted fetal position fit leg contracted to her leg strap on the resident and attached to the bed frame at dent. In 2/26/14 at 10:00AM, NA#1 consible for ensuring the leg resident. The catheter bag he bed frame on numerous In on 2/26/14 at 11:00AM, do in the fetal position the distrapped to the bed frame. In on 2/26/14 at 12:30PM, and remained in same is bag remained strapped to be blood and white sediment. There was no leg strap on It 2/26/14 at 12:35PM, are residents with indwelling a leg strap secured to the further stated that Resident rap, but could not provide Resident #6 could verbally are need for the strap. In the distribution of the strap. In the strap is the strap of that catheter protocol is all shifts which included	F 31	4. The Executive Director will be responsible for reviewing the results of the monitoring with the DCS. The findings will then be presented and discussed at the monthly Quality Assurance and Performance Improvement Committee Meeting for the duration of the monitoring.		

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F 315	and confirmed that it secured to the resid to the bed frame at vito the bed frame at vit	rsing) observed the catheter he catheter bag was not ent's leg and it was secured waist level. Interview on 2/26/14 at cated that she had not put the d Resident #6. Interview on 2/26/14 at 1:05PM, NA#2 theter strap was not esident. Interview on 2/26/14 at 4:40PM, NA#3 is be secured to the resident.	H.	315			
F 318 SS≍D	administrator indicathat director of nursiand ensure that all rhave been met. This catheter bags/tubing	on 2/27/14 at 11:20AM, the led the expectation would be ng monitor the nursing staff nedical needs of the resident would include ensuring that had been secured. ASE/PREVENT DECREASE TION	F	318			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

345403

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

6590 TRYON ROAD CARY, NC 27518

CARY HEALTH AND REHABILITATION

(X4) ID

PREFIX

TAG

SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)

(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5)

COMPLETION DATE

B. WING

F 318 Continued From page 3

Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

This REQUIREMENT is not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to apply splints as ordered by the physician for 1 of 5 sampled residents with contractures (Resident #6). The findings included:

Resident #6 was admitted to the facility on 9/12/13, with multiple diagnoses including contractures of left upper/lower and right upper extremities and pressure ulcers. The admission MDS (Minimum Data Set) assessment dated 9/23/13 indicated that Resident #6 was non verbal, had severe cognitive impairment and required extensive assistance with all activities of daily living.

Review of physician 's order dated 9/23/13, revealed Resident #6 should have a left hand splint to prevent contracture and to increase use of left hand in activities of daily living performance and functional mobility. Another physician 's order dated 10/8/13, documented that Resident #6 required a left elbow splint to manage tone and contracture and left knee splint to improve range of motion and tone.

Review of the care plan dated 9/23/13, identified one of the care plan problems was Resident #6

- F 318
 1. The corrective action taken for the alleged deficient practice was to clarify with therapy and the attending physician the orders for the splints for Resident #6. The Splints were applied to Resident #6 per therapy's recommendation
 - and the physician's order.

 2. Current residents were audited for splint orders and inspected to ensure they were applied as ordered. As well, orders were audited for clarity and details of splint recommendations. Future admissions or readmissions will be evaluated upon admission to determine if any type of splinting is ordered and if so, applied properly.

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02/27/2014

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)RM APPROVED NO. 0938-0391	
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ALTH AND REHABILITAT	ION	1				
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was admitted with cor lower and right upper that Resident #6 would motion to all joints as contracture. The apprapplication of the splir Review of the safe transintenance plan date Resident #6 was to we 30-45 minutes, left hat to prevent further contractions included to prevent further contractions included to losen up muscles of Resident #6 wear the while Resident #6 was resident from bed to we resident from bed to we resident from the to the wheelchair. During an observation Resident #6 was lying an observation of Resident #6 was lying the service was lying the s	extractures of left upper and extremities. The goal was d maintain current range of evidence by no further oaches included the nt/brace per order. Insition goal/functional ed 10/23/13, revealed ear the left elbow splint for nd resting splint for 1 hour tractures, and left knee e hours, however shift dicated. Additional o provide range of motion to left leg before having splint. Apply left leg splint is in bed then stand pivot rheelchair. Inch information kardex indicated while Resident#6 age of motion. After the motion apply the left splint stand and pivot the resident on 2/26/14 at 9:40AM, in bed in a fully contracted	F 318	by Director of Clinical Servi (DCS) and Assistant Director Clinical Services (ADCS) or splint application and corresponding documentation Splint orders were added to Caretracker for nursing assist to document compliance with orders. When new staff memare hired in the future, they was be educated to this process of their orientation to the facility and/or their respective nursing department position. The DO her designee will audit 10 residents with orders for splintsee that the splint is applied correctly and utilized for the proper time. This monitoring be done daily for 1 month, the once per week for 1 month, the once a month for 3 month and then once a month for 3 month and the once a month for 3 month and the saddressed and corrected as needed. 4. The Executive Director will be addressed and corrector and sales.	ices or of on. on. otants h onbers will uring y og CS or ots to g will en hen od ths.		
	ROVIDER OR SUPPLIER ALTH AND REHABILITATI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page was admitted with con- lower and right upper that Resident #6 woul- motion to all joints as contracture. The appreaupplication of the splin Review of the safe tra maintenance plan date Resident #6 was to we 30-45 minutes, left har to prevent further cont splint for 3 consecutive application was not inc instructions included to loosen up muscles of Resident #6 wear the while Resident #6 was resident #6 was resident #6 more te undated, read in part: was in bed provide rar provision of range of n on left knee and then s to the wheelchair. During an observation Resident #6 was lying fetal position with both	ROWDER OR SUPPLIER ALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 was admitted with contractures of left upper and lower and right upper extremities. The goal was that Resident #6 would maintain current range of motion to all joints as evidence by no further contracture. The approaches included the application of the splint/brace per order. Review of the safe transition goal/functional maintenance plan dated 10/23/13, revealed Resident #6 was to wear the left elbow splint for 30-45 minutes, left hand resting splint for 1 hour to prevent further contractures, and left knee splint for 3 consecutive hours, however shift application was not indicated. Additional instructions included to provide range of motion to loosen up muscles of left leg before having Resident #6 wear the splint. Apply left leg splint while Resident #6 was in bed then stand pivot resident from bed to wheelchair. Review of the nurse tech information kardex undated, read in part: indicated while Resident#6 was in bed provide range of motion. After the provision of range of motion apply the left splint on left knee and then stand and pivot the resident	ICONTINUED FOR PAGE A WEDICAID SERVICES OF DEFICIENCIES FORRECTION ICX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345403 B. WING ROWDER OR SUPPLIER ALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 was admitted with contractures of left upper and lower and right upper extremities. The goal was that Resident #6 would maintain current range of motion to all joints as evidence by no further contracture. The approaches included the application of the splint/brace per order. Review of the safe transition goal/functional maintenance plan dated 10/23/13, revealed Resident #6 was to wear the left elbow splint for 30-45 minutes, left hand resting splint for 1 hour to prevent further contractures, and left knee splint for 3 consecutive hours, however shift application was not indicated. Additional instructions included to provide range of motion to loosen up muscles of left leg before having Resident #6 was in bed then stand pivot resident from bed to wheelchair. Review of the nurse tech information kardex undated, read in part: indicated while Resident#6 was in bed provide range of motion. After the provision of range of motion apply the left splint on left knee and then stand and pivot the resident to the wheelchair. During an observation on 2/26/14 at 9:40AM, Resident #6 was lying in bed in a fully contracted fetal position with both arms and left leg	STOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES OF DEFICIENCIES OF DEFICIENCIES OF DEFICIENCIES OF DEFICIENCIES OF DEFICIENCY OF DEFICIENCY OF DEFICIENCY A SUND DEFICIENCY OF DEFIC	SEFOR MEDICARE & MEDICARD SERVICES SEFOR MEDICARE A MEDICARD SERVICES OF DEFICIENCIES F CORRECTION (X1) PROVIDERSUPPLIER A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE SSO TRYON ROAD CARY, NC 27618 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 was admitted with contractures of left upper and lower and right upper extermities. The goal was that Resident #6 would maintain current range of motion to all joints as evidence by no further contracture. The approaches included the application of the splint/brace per order. 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During an observation on 2/26/14 at 9:40AM, Resident #8 was lying in bed in a fully contracted fetal position with both arms and left leg splint with both arms and left leg splint with both arms and left leg splint with the provision of range of motion apply the left splint on left knee and then stand and pivot the resident to the was lying in bed in a fully contracted fetal position with both arms and left leg resident #6 was lying in bed in a fully contracted fetal position with both arms and left leg resident #6 was lying in bed in a fully contracted	

worn.

During an interview on 2/26/14 at 10:00AM, NA#1

indicated that Resident #6 had worn splints on

added that the splints had not been around for

awhile and was not sure when they should be

her arms/legs in the past when in bed. NA#1

place

DCS. The findings will then be presented and discussed at the

monthly Quality Assurance and

Performance Improvement

Committee Meeting for the

duration of the monitoring.

3/19/14

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NAME OF PROVIDER OR SUPPLIER CARY HEALTH AND REHABILITATION			STF 659	REET ADDRESS, CITY, STATE, ZIP CODE 90 TRYON ROAD ARY, NC 27518	02	/27/2014	
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F 318	Continued From page	5	F	318			
		n on 2/26/14 at 11:00AM, e fetal position without					
	During an observation Resident #6 lying in b splints.	n on 2/26/14 at 12:30PM, ed in same position without					
	During an interview at #1 confirmed that Res splints.	t 2/26/14 at 12:35PM, Nurse sident #6 did not have the					
	DON (director of nurs should apply resident physician and recommadded after review of have been some clari- use of the splints. DO	n 2/26/14 at 12:45PM, the ing) indicated that staff splints as ordered by mended by therapy. She the record there should by of the frequency for the N observed Resident #6 in at there were no splints in					
	During a follow-up into 12:55PM, NA#1 confir not have splints on.	erview on 2/26/14 at med that Resident #6 did				: : !	
	indicated that Resider splints but was uncert should wear them thro they had not been ava	n 2/26/14 at 1:05PM, NA#2 at #6 supposed to wear the ain how long Resident #6 sughout the day because silable for sometime.NA#2 time frame in which the					
	rehabilitation manager was admitted with con	2/26/14 at 1:37PM, the indicated that Resident #6 fractures and required to r splint and left leg splint to					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/14/2014 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ С 345403 B. WING 02/27/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6590 TRYON ROAD CARY HEALTH AND REHABILITATION **CARY, NC 27518** SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 318 | Continued From page 6 F 318 prevent further contracture. The Rehabilitation manager indicated the staff was expected to apply the splint as ordered by physician. The rehabilitation manager added that nursing staff had been educated on the application of the splints and she was unaware that they were not being applied. During an interview on 2/26/14 at 4:40PM, NA#3 indicated being unaware of Resident #6 wearing During an interview on 2/26/14 at 4:45PM, NA#4 indicated being unaware of Resident #6 wearing splints since they had not been seen. NA#4 did not indicate how long the splint was missing. During an interview on 2/26/14 at 5:18PM, Nurse #2 stated physical therapy applied the splints on during the day and was uncertain how long they should be worn. During an interview on 2/27/14 at 11:20AM, the administrator indicated the expectation would be that the director of nursing monitor the nursing staff and ensure that all medical needs of the resident have been met. This would include ensuring that resident preventative devices (splints) were applied according to physician orders.